

TREATMENT PLAN FOR PHYSIOTHERAPY/ CHIROPRACTICE/ ACUPUNCTURE



(All sections must be completed)

SECTION A - PARTICULARS OF THE PATIENT

Name of Patient: _____ Sex: _____

Date of Birth (day/month/year): _____ Member No.: _____ Policy No.: _____

If group insurance, name of Policyholder: _____

SECTION B - TREATMENT PLAN RECOMMENDED BY THE ATTENDING PHYSICIAN

Diagnosis: _____

Recommended Treatment: _____

Does the patient need Physiotherapy/ Chiropractic/ Acupuncture treatment? ☐ Yes ☐ No

Type of treatment needed: _____

How many treatment visits does the patient need? _____

Expected completion date of treatment: _____

Does the patient need wound care? ☐ Yes ☐ No

Type of wound care needed _____

How many visits does the patient required for wound care? _____

Expected completion date of wound care treatment: _____

Does the patient need follow-up visit(s)? ☐ Yes ☐ No

How many visit(s) is/are required? _____

Date of last follow-up: _____

Name of Attending Physician: _____

Address: _____

Tel: _____

E-mail: _____

Signature of Attending Physician with stamp

Date (day/ month/ year): _____